Self-Insurance: The Impact of Health Reform

Health Reform accelerated the trend to self-insure health plans, large and small. The Department of Labor's annual reports have not identified any negative impact on participant benefits or the public marketplace exchanges.

Plan sponsors of self-insured plans should ensure that plan document provisions authorizing the use of discretion by the plan administrator are in sync with any purchase of stop loss insurance.

1. In the initial 2011 report on self-insurance, RAND concluded, in part:

- There was little evidence that self-insured plans differ systematically from fully insured plans in terms of benefit generosity, price, or claims denial rates.
- Using Kaiser data, in 2010, 10.9% of plans were self-insured, covering 58% of all participants.

Among the hundreds of provisions that were part of Health Reform (PPACA)[i] legislation, Congress directed the appropriate agencies to provide an annual report regarding employers who self-insure their health plans.

Congress believed an annual report was necessary because of concerns that smaller businesses might self-insure as a means of avoiding certain costly PPACA compliance requirements[ii] and that the decision to self-insure would remove heathier risks from the public marketplace exchanges.

RAND completed the initial report[iii] in early 2011 (see sidebar #1). RAND did not find 'major differences in benefit generosity between self-insured and fully insured plans or major threats of adverse selection in the small-group market.'

Health Reform had its largest impact on employer-sponsored plans in the years after 2014 in large part due to the addition of the employer mandate which applied to employers with 50+ full time equivalent employees.

The most recent report on self-insurance was issued by Secretary of Labor Marty Walsh in March 2023[iv] (see sidebar #2). A lack of data 'make it difficult to draw conclusions regarding the financial health of a company and its choice of funding mechanism for its health plan.' Established large plan continue to move away from being fully insured and are more likely to terminate. New plans are dominated by small, self-insured plans.

Stop Loss Prevalence

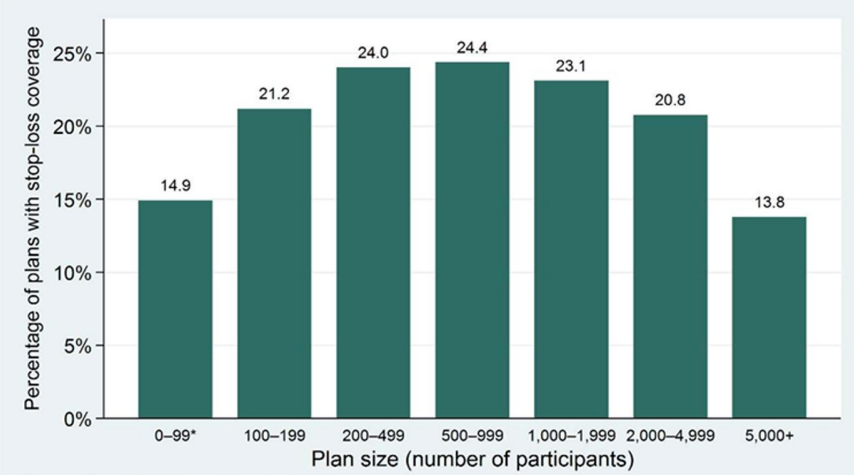
From 2011 to 2020, the percentage of large group health plans that reported having stop loss insurance gradually declined, from approximately 27% to 22% for self-insured plans and from 21% to 17% percent for large mixed-insured plans.[v] However, the percentage of self-insured small plans that

The use of self-insurance, in 2010, substantially varied based on the size of the plan:

- There are no nationally representative data on the availability, prevalence, pricing, or contracting terms of stop-loss insurance.
- Sixteen states have regulations that prohibit insurers from selling stop-loss policies with attachment points below specified limits, which range from $5,000 to $25,000.
- Consumer recourse options for denied claims are generally more limited for self-insured than for fully insured enrollees. However, PPACA partially addresses the second concern by creating a right to external review.
- A sizable increase in self-insurance (will occur) only if comprehensive stop-loss policies become widely available … and the expected cost of self-insuring with stop-loss is comparable to the cost of being fully insured in a market without rating regulations.
- For all other scenarios, the change in self-insurance predicted by the model is small, and reflects that even with stop-loss coverage, self-insurance remains risky for small firms.

reported having stop-loss insurance increased from 13% to 42%, though the percentage of mixed-insured plans that reported having stop-loss insurance decreased from 48% to 33%.

Self-Insured Large Health Plans' Rate of Stop-Loss Coverage, by Plan Size (2019)



Source: Form 5500 filings of large health plans.
Reflects stop-loss coverage as reported on Form 5500; see text.
* The definition of a large plan is based on number of participants at the beginning of the reporting period; some large plans have fewer than 100 participants at the end of the period.

Stop Loss Regulation

Soon after Health Reform took effect, a controversy arose about when stop loss insurance might be regulated as health insurance. The controversy centered on stop loss policies that used a very low attachment point, and/or covered plans with a very small number of participants. Some states responded to concerns by adopting limits on stop loss coverage – generally along the lines of the National Association of Insurance Commissioners (NAIC) Stop Loss Insurance Model Act, including:

- A minimum attachment point
- A minimum group size
- Limitations on lasering

Because most states focused on those limitations, we have not seen any ERISA preemption litigation specifically focused on curtailing a state's regulation of stop loss insurance. Litigation to date has confirmed that stop-loss insurance is not considered to allow states to treat the plan as insured for ERISA preemption purposes.[vi]

In 2014, the Department of Labor (DOL) issued sub-regulatory guidance that confirmed states could regulate stop loss insurance so long as:

2. The Department of Labor report, March 2023, concluded:

- *The distribution of plan participants in employer-sponsored plans has remained largely unchanged, with self-insured plans covering about 45% of participants, fully insured plans 18%, and combination plans 37%.*
- New plans were mostly small, self-insured plans, with growth driven by an influx of filings by small plans participating in multiple employer welfare arrangements (MEWAs).
- Self-insured plans had 35 million participants, $112 billion of assets. Mixed-insured plans had 29 million participants, $157 billion in assets.
- Self-insurance is more common among larger employers where expenses are more predictable, triggering less risk of unanticipated losses.

Form 5500 data are incomplete – excluding plans with less than 100 participants, that do not hold assets in trust, and are not part of a Multiple Employer Welfare Arrangement (MEWA) or Entities Claiming Exception (ECE). So, data from most employer-sponsored, ***small*** plans are not captured, and are not included in the report.

- The regulations did not affect the underlying self-insured plan, and
- The stop-loss policy does not become the primary health coverage – directly covering individual health care expenses.

According to the DOL, "A state law that prohibits insurers from issuing stop-loss contracts with attachment points below specified levels would not be preempted by ERISA."[vii] Importantly, the stop loss policy must clearly provide insurance to the plan sponsor against financial loss and not indirectly insure specific participant claims.

Action

The health plan document and summary plan description should clearly confirm the plan administrator's discretionary authority, and, as appropriate, the plan sponsor should confirm that there are no unintentional inconsistencies between coverage under the plan and any stop loss insurance.[viii]

Some Final Observations

The 2023 self-insurance report does not mention any concern about the impact of self-insurance on the public marketplace exchanges.

Self-insured plans are not required to be funded, nor to hold assets in trust. In fact, tax code provisions limit the ability to fund liabilities on a tax-preferred basis.[ix] Self-insured plans that are not funded are overwhelmingly comprised of active workers (90+%). For comparison, among self-insured plans with trusts/funding, 25+% of the covered population is no longer actively employed. Nonetheless, the Form 5500 data show that in the 19,700 plans that are funded, there are 20 million participants with $369 Billion in assets, or an average amount of assets per participant of $18,450.

Your Medical Billing Partner

Many employer-sponsored health plans have recently completed annual enrollment processing. Yet, it is already time to start preparing for 2024. Benefit administrators should take strategic action to ensure that their health plans incorporate the most effective strategies for addressing today's economic challenges to the "health and wealth" of their participants.

As your partner, aequum can help evaluate and facilitate the most effective strategies for countering inflation, including HSA-capable coverage, reference-based pricing with adequate participant protections against balance billing, participant advocacy and litigation support.

These strategies are proven to lower costs, achieve savings and improve plan member experience. Please contact us if you have any questions or need for support. www.aequumhealth.com.

Percentage of Firms Offering a Self-Insured Health Plan in 2010

Firm Size (number of employees)	Offer Only Self-Insured Plans	Offer Mix of Self-Insured and Fully Insured Plans	Offer Only Fully Insured Plans
3–49	5.90 (1.76)	2.0 (1.79)	92.1 (2.47)
50–199	19.4 (3.16)	0.9 (0.61)	79.7 (3.19)
200–999	45.3 (3.13)	2.7 (0.74)	52.1 (3.13)
1000+	61.7 (2.39)	18.7 (2.01)	19.6 (1.90)

NOTE: Rates among firms offering at least one health plan, calculated by authors' analyses of Kaiser/HRET data. Standard deviations shown in parentheses.

[i] Patient Protection and Affordable Care Act of 2010 (PPACA), Pub. L. 111-148, Signed by President Obama, 3/23/10.

[ii] Compliance is costly for self-insured plans because they are not subject to PPACA's small-group rating regulations, risk adjustment policies, and essential health benefits requirements. Self-insured plans also avoid state insurance regulations, state-specific benefit mandates and state premium taxes. Congress believed that more small plans (< 100 participants) would self-insure to take advantage of situations where their workers were healthier – avoiding those expenses and compliance requirements. And, as more small employers self-insured, those employers who selected coverage via the marketplace exchanges would disproportionately consist of high-risk, potentially expensive workers and family members – the classic definition of adverse selection. Congress also expressed concern that self-insurance might impact a participant's benefits due to conflicts in interest between plan sponsors and participants, as well as employer solvency - increasing the probability of claim denial, financial risk, and reducing recourse options for denied claims.

[iii] C. Eibner, F. Girosi, A. R. Miller, A. Cordova, E. A. McGlynn, N. M. Pace, C. C. Price, R. Vardavas, C. R. Gresenz, Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act, as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA), RAND, 3/28/11, Accessed 4/3/23 at: https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//138076/EmployerSIDACA.pdf

[iv] M. J. Walsh, Annual Report on Self-Insured Group Health Plans, March 2023, Accessed 4/3/23 at: https://www.dol.gov/sites/dolgov/files/EBSA/researchers/statistics/retirement-bulletins/annual-report-on-self-insured-group-health-plans-2023.pdf

[v] M. J. Walsh, note iv, supra. See also: C. W. A. Panis, M. Yeretsian, Self-Insured Health Benefit Plans 2022 – Based on Filings through 2019, Advanced Analytical Consulting Group, Inc. 9/24/21, Accessed 4/4/23 at: https://www.dol.gov/sites/dolgov/files/EBSA/researchers/statistics/retirement-bulletins/annual-report-on-self-insured-group-health-plans-2022-appendix-b.pdf

[vi] See: Hua v. Board of Trustees, 2021 WL 2190906 (D. N.J. 2021) The court noted that the presence of stop loss insurance does not make the plan insured for ERISA purposes, while cautioning that stop loss with a very low attachment point might suggest that a plan is not truly self-insured where little or no risk is retained by the plan sponsor.

[vii] Department of Labor, Technical Release No. 2014-01, Guidance on State Regulation of Stop-Loss Insurance, 11/6/14, Accessed 4/4/23 at: https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/14-01

[viii] For example, see: Computer Aided Design Sys. v. Safeco Life Ins. Co., 358 F. 3d 1011, 8th Cir. 4/9/04, Accessed 4/4/23 at: https://caselaw.findlaw.com/us-8th-circuit/1207273.html

[ix] Internal Revenue Code §§419, 419A